made whereby ophthalmologists will delegate to opticians wherever practicable the bulk of refraction work, in the knowledge that such work will be carried out to the entire satisfaction of both professions." In 1948 the introduction of the supplementary ophthalmic service effectively prevented any collaboration between ophthalmologists and ophthalmic opticians, took from the ophthalmologist his right to diagnose and treat his patients, and created a demand for outpatient treatment which the hospital eye service has never been able to satisfy.

The time is again opportune to try to improve the eye service of the nation along the lines suggested by Scoular and Professor Russell. There would be a shift of emphasis from the hospital to a community-based service[3] in which diagnosis and treatment would be provided as well as refraction, and ophthalmologists and opticians would work together as a team. At the apex of the pyramid would be the ophthalmic consultant surgeon in hospital; in the next tier would be four ophthalmic specialists (at present graded S.H.M.O., Medical Assistant, O.M.P., or Para 94 appointment) working mainly in the community but also in the hospital outpatient service; in the third tier would be some 16 ophthalmic opticians, and in the fourth dispensing opticians supported by frame stylists and receptionists.

Team effort and a pyramid plan would achieve the best results with the amount of national income available, would increase the sense of commitment of staff to the local population, and exercise the intellect of ophthalmologists and opticians to better advantage.—I am, etc.,

P. RICHARD DAY

Tonbridge, Kent

1 Scoular, L. G., *British Medical Journal, Supplement*, 1944, 2, 10.
2 Giles, G. H., *The Ophthalmic Services under the N.H.S. Acts 1946-52*. Appendix X. London, Hammond, 1953.
3 Office of Health Economics, *Building for Health*. London, O.H.E., 1970.

Prevention of Deep Vein Thrombosis

SIR,—I have followed the correspondence on this subject with interest, particularly on the question of intermittent pneumatic compression of the legs in the prevention of deep vein thrombosis. I would, however, like to put the record straight with regard to the statement made by Dr. N. H. Hills and others in their letter (1 April, p. 49) when they say that their series reported at the Surgical Research Society in July 1971 was the first report. On 21 November 1964 I reported a series of cases treated by intermittent pneumatic compression at the Surgical Research Society and subsequently demonstrated the same method at a symposium at the Liverpool Medical Institute in January 1965, and subsequently reported in the journal of that institute.—I am, etc.,

D. W. BRACEY

Peterborough District Hospital,
Peterborough

Coalminers' Pneumoconiosis

SIR,—Dr. J. P. Lyons and his colleagues (18 March, p. 713) reach a conclusion which is in conflict with the evidence they present. This is that "the excess emphysema in the pneumoconiosis cases, shown in our earlier paper . . . is an integral and significant part of the disease." Yet the impairment of ventilatory function which they attribute to emphysema was greater in men without than in those with simple pneumoconiosis. Since there is now good evidence that the radiological category of pneumoconiosis is well related to the dust content of the lungs,[1] the evidence in this paper supports the conclusion that there is no relationship between disability and amount of dust in the lungs which has previously been established in epidemiological studies, and it counters their own conclusion that simple pneumoconiosis is a cause of emphysema.—I am, etc.,

C. M. FLETCHER

Royal Postgraduate Medical School,
London W.12

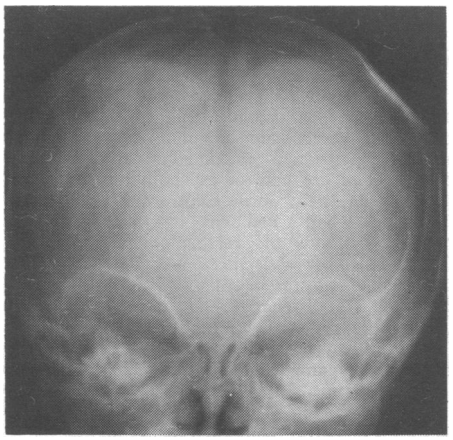
1 Rossiter, C. E., *British Journal of Industrial Medicine*, 1972, **29**, 31.

Reduction of Pond Fracture

SIR,—An easy method of reducing pond depressed fractures in infants is described.

A boy aged 5½ months was brought to our paediatric outpatient department with a depressed pond fracture of the left parietal bone. The evening before he had been carried around on the back of a house maid, as is usual in African countries. In the morning the mother noticed a depression in the head. Although at first strongly denied, it was later admitted by the girl that the baby had fallen from her back.

The depression was about 4½ cm in diameter. Physical examination did not reveal any other abnormality; notably no neurological disorder was found. It was decided to use the vacuum extractor to reduce the fracture (Fig.). A suction-cup of 50 mm



diameter was applied over the depression. No anaesthetic was given. Negative pressure was quickly increased to 0·8 kg with the Malström-vacuum hand pump. Suction was kept on for four minutes, after which the cup was removed. No traction was exerted. As soon as the caput succedaneum had decreased, palpation revealed the fracture to be reduced and this was confirmed by one *x*-ray. After some hours the child was sent home. On subsequent visits the child was found to be perfectly well.

Pond depressed fractures are not rare in Africa because children tend to fall down from the backs of their mothers or nannies. In the last 18 months we have dealt with three cases, of which the first one, in a child of four months, was reduced according to the method described in Hamilton Bailey's *Emergency Surgery*.[1] In the second case, an infant of seven months, the vacuum extractor was successfully used. Within the same period the vacuum extractor was used on three occasions to reduce pond depressed fractures sustained in labour. On each occasion a period of 24 hours was allowed to lapse before reducing the fracture. No complications were encountered. In the last of these cases two minutes' suction at 0·8 kg was sufficient.

Although the perforation traction method of reducing pond fractures is quite easy and satisfactory, it is considered that the method here described is even easier and safer, especially in circumstances prevailing in underdeveloped countries. Inadequate surgical asepsis and limited surgical experience of the attending doctor in tropical upcountry hospitals could make perforation of the skull hazardous.

The dangers inherent to the use of the vacuum extractor are minimal because the time of suction is short and traction is not exerted.

I wish to thank Mr. C. B. Sedzimir for his encouragement to report the method.

—I am, etc.,

A. VAN ENK

Agogo Hospital,
Agogo (A.A.), Ghana

1 Bailey, Hamilton, *Emergency Surgery*, 8th edn., ed. T. J. McNair. Bristol, John Wright, 1967.

Suction Retractor

SIR,—It is difficult to cover the literature thoroughly. The suction retractor described by Mr. Michael Burke (8 April, p. 112) is similar to the one I described in the *Lancet* in 1964.[1] Its use was to retract friable tissue as mentioned in the letter.—I am, etc.,

JOHN SHIPMAN

Lister Hospital,
Hitchin, Herts

1 Shipman, J. J., *Lancet*, 1964, **1**, 1424.

Recurrent Urinary Infections

SIR,—We think that for the sake of the record we should point out to Dr. H. G. Jones (8 April, p. 113) that Hugh and Andy did not advocate routine tomography at the time of an intravenous pyelogram. It was a chap called Henry (11 March, p. 688).—We are, etc.,

R. HUGH JACKSON
ANDREW SMITH

Children's Department,
Royal Victoria Infirmary,
Newcastle upon Tyne

The Doctor in Conflict

SIR,—Your leading article (25 March, p. 761) deserves comment. In it you state "Moreover, there is no reason to suppose, and no shred of evidence, that any doctor in the recent troubles has departed from the ethical traditions that guide the profession." Yet you do not quote the source of this information. Are we to use traditions as guidelines? If so what role do the Declaration of Geneva and of Helsinki, and the International Code of Medical Ethics, play?[1] I and other doctors in Ireland signed a letter addressed to the General Medical Council requesting an investigation into the behaviour of doctors during the interrogation of detainees. In its reply it said it was not within the province

of the G.M.C. to undertake an investigation. As a result of this another letter was signed, again requesting an investigation, and we are waiting for a reply.—I am, etc.

T. F. C. S. WARNER

Rochester,
Minnesota, U.S.A.

1 *World Medical Journal*, 1972, **19**, No. 2, 28, and 29.

"Cot Deaths"

SIR,—In his article "Welfare of Families of Children Found Unexpectedly Dead ('Cot Deaths')" (4 March, p. 612) Dr. John L. Emery refers to the midwife as being held in much higher confidence than the health visitor, especially in densely populated industrial areas. By implication he suggests that, even as late as six months after birth, they would be more acceptable than the health visitor in supporting the family after a cot death. As 80% of babies are now born in hospital and, of those born at home, the midwife seldom visits after the tenth day, it seems unlikely that there would be an established relationship between them.

The health visitor will in most cases have seen the mother and baby several times in the period between birth and sudden death. This may, as Dr. Emery suggests, put her in a somewhat similar situation to the doctor, but in most cases her training and knowledge of the family will make her acceptable and enable her to give support in this most distressing situation.

There is a pilot scheme being tried in one authority where a doctor and health visitor are officially notified of these deaths, and make the first visit jointly to avoid the additional trauma of a policeman visiting the parents at such a time.—I am, etc.,

G. M. FRANCIS
Editor, *Health Visitor*

London S.W.1

Summer Camp for Diabetic Children

SIR,—Every year the British Diabetic Association runs camps for diabetic children in the summer holidays. These have proved to be of inestimable benefit to these children, where they adjust to their disability as members of a group and things such as diet and injections are as much a part of daily routine as washing and dressing and not things which mark a child as being "different."

This year we hope to cater for 250 children, but this depends on finding adequate staff to look after them. May I appeal through you to any doctor who will be willing to give up two weeks of his time for this worthwhile work, to ask them to write to me at this address for further details.—I am, etc.,

T. D. KELLOCK
Chairman of the Children's Committee,
British Diabetic Association

3-6 Alfred Place,
London W.C.1

Design of the E.C.10

SIR,—I am sure it has not escaped the notice of my colleagues that with the introduction of the "N.P." box on E.C.10's, the area available for writing a prescription is now reduced to 6·4 sq in of effective space—that is, 23% of the total area of the prescription form.

The space available for the address is now 1·6 in (3·75 cm) long in which one is expected to write the number and name of the street. If there are more than 10 letters in this the writing inevitably becomes illegible.—I am, etc.,

H. KAY

Middlesbrough

Journals Galore

SIR,—Magazines, periodicals, and journals drop daily through the surgery letter box. Is it not time to call a halt before this hailstorm of newsprint engulfs us totally? A relative newcomer to general practice, I have been appalled at this wasteful method for the dissemination of more or less useful knowledge.

My sample this fortnight included the *B.M.J.*, *Update*, *World Medicine*, *Modern Medicine*, *Journal of the Royal College of General Practitioners*, *Modern Geriatrics*, and *Health Trends*, plus the tabloids *Pulse*, *Medical Tribune*, *Doctor*, and *London Doctor*, and this list is not exhaustive. Some of these journals are solicited, most are not; certainly the sheer physical and mental impossibility of reading more than a tiny proportion of the contents—themselves possibly distilled fragments—of these doubtless excellent publications, adds up to the most wasteful example of consumer society affecting the medical profession.

We do not need more journals. The existing ones could be constructively culled and we might be left with fewer but better papers to read.—I am, etc.,

P. M. O'DONNELL

Dunstable, Beds

Points from Letters

Abortion Act

MR. H. P. DUNN (Auckland, New Zealand) writes: The B.M.A.'s Memorandum of Evidence to Mrs. Justice Lane's Committee (*Supplement*, 29 January, p. 33) quotes Forssman and Thuwe,[1] who followed up 21 years later a group of 120 children born after therapeutic abortion had been refused. They found them more mentally disturbed, socially disadvantaged, and educationally backward than a control group. The B.M.A. committee should not have accepted so uncritically these findings in favour of abortion. While the article records a unique and assiduous follow-up, the key question, which is always overlooked when this paper is quoted, is: what was the initial selection of the abortion-seeking patients? The article reveals that they were all patients of the Psychiatric Department of the Sahlgren Hospital. . . .

1 Forssman, H., and Thuwe, I., *Acta Psychiatrica Scandinavica*, 1966, **42**, 71.

Psychotherapy Facilities

Drs. S. E. BROWNE and N. L. SHORT (Dartford, Kent) write: In recent years we have become increasingly concerned about the difficulty in securing adequate psychotherapy for our patients, and in particular for selected groups such as adolescents and patients with marital problems where even limited treatment can often secure considerable improvement. . . . No help is at present available for large numbers of patients for whom some form of skilled psychotherapy could improve not only the quality of their lives, but possibly make a vital difference to the future mental health of the community. Shortage of trained personnel inevitably tends to influence psychotherapy in the direction of group treatment and therapeutic communities, and many general practitioners in the London area have been glad of the help of psychotherapeutic units such as the Ingrebourne Centre and the Cassell Hospital when orthodox psychiatry using physical methods of treatment has completely failed to be of assistance. We feel very concerned at present that plans for basing psychiatry in district general hospitals may not only fail to provide more badly needed facilities for group psychotherapy, but . . . lead to the closure of existing centres. . . .

Record Folder for General Practice

Dr. I. S. L. LOUDON (Wantage, Berks) writes: Dr. J. L. Struthers (1 April, p. 50) feels that the A4 system "encourages the accumulation of rubbish" (sic). This is the opposite of the truth. It is much easier to remove records that are no longer needed from an A4 folder, where they are easily seen, than from a medical record envelope, where they are folded and buried out of sight. . . . Dr. A. J. Laidlaw (1 April, p. 51) puts in a plea for size A5 on the grounds of size and cost. Certainly A5 is half the size of A4 but, for a similar design, we doubt if the costs of production would differ greatly. It is labour and processing that are the main expenses, not the quantity of the basic material. . . . The hospital service uses A4 records for one episode of illness. We have to cater for the medical records of a patient's lifetime, covering all aspects of medicine. We feel that this justifies the A4 size and would refer you to our paper (11 December 1971, p. 667) for the evidence that a large majority of doctors who have used A4 folders share this view.

Doctors and Overpopulation

Dr. B. PASTAKIA (Students Hostel, All India Institute of Medical Sciences, New Delhi, India) writes: I have read with interest the correspondence sparked by Dr. J. A. D. Anderson and colleagues (8 January, p. 108). It might interest your readers to know that an international medical students' seminar was held in the first week of March on the very same topic at New Delhi. There were delegates from about 30 countries to this seminar, and there was complete unanimity in expressing the opinion that in view of the magnitude and urgency of the population problem the medical profession has a very significant part to play in facing the challenge—the one of leadership. . . . An International Medical Students Organization on Population was set up with the objectives of: (*a*) International exchange of ideas and information between medical students on population dynamics and family planning in medical education. (*b*) Encouraging production and worldwide availability of teaching aids in the field of population dynamics and family planning to assist in the education of the medical graduate. (*c*) Encouraging and where practicable assisting national and college student bodies to conduct seminars and studies in this field. . . . The All India Medical Students Association agreed to sponsor a seminar on medical education later this year. . . . A similar move in Britain would be quite useful, and British students who feel strongly about it may express their views to me. . . .